Identifying best practices for care-dependent elderly by Benchmarking Costs and outcomes of community care

Review on the structure of community care of the six participating countries and their benchmarking practices

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Abstract

The overall aim of IBenC project is to identify best practices in community care delivery for care dependent community dwelling elderly people by benchmarking the cost-effectiveness of community care delivery systems across Europe. To understand why some organisations and health care systems provide better quality of care than others, studying the micro (client), meso (organisation) and macro (policy) levels is equally important. This report focuses on the macro level.

The aim of this report was to review and compare the context, regulations and conditions for community care system delivery to care dependent elderly on the macro (country / regional) level in countries that participate in IBenC (Belgium, Finland, Germany, Iceland, Italy and the Netherlands). The following dimensions of community care were described and benchmarked: governmental vision, governmental regulation, funding, organisations and professionals, eligibility criteria and equity and the involvement of informal caregivers and placed in the context of proportion of aging persons and welfare level. To this end, indicators were used based on two recent literature reviews on community care in Europe and an international comparative study. The descriptions from EurHOMap of the community care system were updated per IBenC country.

In summary, the Netherlands have the most formal home care with low informal care use, while Italians essentially have to rely on informal care. Home care in Belgium distinguishes itself from home care in the other countries by the definition of nursing care, which also includes personal care such as washing, toileting and dressing. In Germany, more than half of the home care organisations are for profit and are very small. Since municipalities are primarily responsible for home care in Finland, Finland has the most decentralised home care regulation. Finally, the home care system in Iceland is less formal, due to the young population. Nevertheless, Iceland is also preparing the home care system for an ageing population in the near future.

1 Introduction

The population of Europe is ageing. The average European percentage of the population over 65 years will increase from 16 % in 2010 to 27.8 % in 2050. Consequently in 2050, there will be one out of five people in Iceland up to one out of three people in Germany and Italy, who will be 65 years or older (1). Also, the proportion of people aged 80 years or older is expected to increase from 4.1 % in 2010 to 10 % by 2050 ((1);(2). Associated with this, there will be an increasing number of frail and disabled older persons who need long-term care (2);(3);(4). In most OECD countries[1] four in five long term care users are older than 65 years, and around half of the long-term care users are over the age of 80. Of all formal long-term care, between half and three quarters is provided in the home-care setting. (4)

Currently, 40% of public spending on health care is for people of 65 years and older (4);(5), with hospital admission and admission to long-term care facilities as main cost drivers (6);(7). Part of these admissions is premature or unnecessary. The expected increase in the population of older persons will put great pressure on public spending in the future. Altogether, this will put the health and social care provision for frail elderly people in Europe under great (economic) pressure. Provision of high quality care to this population in their own home may postpone or even avoid early and unnecessary admission to hospitals and long-term care settings. High quality community care for older people, including medical and social services, may prove to be a cost effective solution for the future in comparison with institutionalisation, and may help to maintain the sustainability of European health care systems, while bearing in mind elderly people's wish for autonomy.

The overall aim of IBenC is to identify best practices in community care delivery for care dependent community dwelling elderly people by benchmarking the cost-effectiveness of community care delivery systems across Europe.

The innovative approach of IBenC is its' focus at the relationship between performance (or quality of care) and the input or investment (in terms of money, staff, structures and processes within care organisations, and collaboration with the care system) to reach this level of performance.

To reach this overall aim, two main objectives are addressed;

1) Benchmark costs-effectiveness of community care: care models for elderly people living at home across Europe will be benchmarked using a newly developed integrated measure of cost of care utilisation with quality of provided care. First, the performance (by means of quality indicators (QIs)) of community care organisations is identified, subsequently the costs for the achieved level of quality of care are calculated. This will result in the identification of best practice costing models for care-dependent elderly people at home in Europe.
2) Characterise best practices: describe the most cost effective practices in terms of staff characteristics, management structures, care processes, and reimbursement systems, based on the performed benchmark study.

In Europe, there is a large variation in funding, organisation, and delivery of community based care (8);(9);(10). To understand why some organisations and health care systems provide better quality of

[1] OECD countries means countries that are connected to the Organisation for Economic Co-operation and Development. This report included 29 OECD countries, covering Europe, Australia, United States, the United Kingdom and Korea.

care than others, studying the micro (client), meso (organisation) and macro (policy) levels is equally important. As Donabedian's model illustrates, to assess quality of care, we need to obtain information about the causal linkages among the structural elements of the setting in which the care is given, the processes of care and the outcomes of care (11).

To assess the outcomes of care, client data (micro level) will be collected by using the interRAI Home Care instruments. Structural elements and processes of care will be examined by collecting data of the care giving staff and the home care organisations (meso level). Therefore, online standardised questionnaires are developed within the IBenC project. To identify best practices for care dependent older persons, the data on micro and meso level will be analysed across the participating IBenC countries. During these analyses, it is possible that differences emerge which cannot be explained by the variables on the meso or micro level. To indicate those differences, it is important to contextualize them within the macro level context. The macro level contains the organisation of the community care system in the participating IBenC countries.

The aim of this report was to review and compare the context, regulations and conditions for health care delivery to care dependent elderly on the macro (country / regional) level in countries participating in IBenC.

In the **method section**, the structure to describe and to benchmark the IBenC countries on the macro level is explained. The **results section** consists of four parts. In a first part, some indicators concerning the population, the budgets and the care professionals are described. In a second part, a description of the community care systems per participating IBenC country is given. The third part deals with analyses of equity and in the fourth part consist of a description of the typology of long term care systems based on use and financing of care. The differences and similarities across the IBenC countries are treated in the **discussion section**.

2 Method

The structure to describe and to compare the IBenC countries at the macro-level is based on two recent literature reviews on community care in Europe (12);(13), an international comparative study to explain governmental involvement in home care across Europe (14) and an additional paper (15). Data was collected regarding:

- Governmental vision on community care
- Governmental regulation on community care
- Funding of community care, such as total health costs, client co-payment and reimbursements.
- Organisations and professionals providing community care.
- Eligibility criteria for and equity in receiving care.
- Involvement of informal care

To compare these dimensions across the participating IBenC countries, indicators were used coming from the following sources:

- Eurobarometer (European Commission, 2007), (16)
- ANCIEN project (European Network of economic Policy Research Institute, 2012), (17)(31)
- European Centre for Social Welfare Policy and Research (2012), (18)
- Health consumer Powerhouse (2013) (19)
- EurHOMap project (European Observatory on Health Systems and Policies, 2012);(20)
- Eurostat (2013) (21);(22)
- European Commission – European economy (2012) (23) and
- Organisation for Economic Co-operation and Development - OECD data (2013) (24);(18)

Also, we used the case reports of the EurHOMap study (Home Care across Europe. Current structure and future challenges) in which the home care systems of the different countries were described (25)-(30). These were summarised in country specific tables. These country specific tables were subsequently checked by the IBenC partner in that country, bearing in mind the following questions:

1. Is the information in the document correct?
2. Is the information sufficiently detailed? If not, please add the information you think is missing.
3. Is the information up to date or do you have more recent information?
4. Are there things that should be added because the region(s) included for the IBenC project have specific characteristics or regulations?

In this way, updated indicators and country specific descriptions on the home care systems were developed for the IBenC project.

3 Results

3.1 Indicators across the participating IBenC countries

The population

Table 1 shows that of the participating IBenC countries, Germany has the largest population and Iceland the smallest (80.5 million inhabitants in Germany versus not even a half million inhabitants in Iceland). With 3.2 inhabitants per km², Iceland also has the lowest population density, compared to the other participating IBenC countries, but also compared to the whole of Europe (30). Finland also has a population density lower than the average in Europe (17.7 inhabitants per km² versus 116.9 per km²). The other IBenC countries have a population density above the European average, with The Netherlands being extremely densely populated (494.5 inhabitants per km²) (26).

In every IBenC country, the population is ageing. The average European percentage of the population over 65 years is expected to increase from 16 % in 2010 up to 27.8 % in 2050. Iceland has a high proportion of young people, with only 12% over the age of 65 years and around 3.5% aged over 80 years. This proportion of 12% is expected to increase to 20% by 2050. Consequently, in 2050 one out of five people in Iceland and one out of three people in Germany and Italy who will be 65 years or older (1). This implies an increasing number of dependent older people. The old-age dependency ratio is the ratio between the total number of elderly persons of an age at which they are generally economically inactive (aged 65 and over) and the number of persons at a working age (from 15 to 64) (Eurostat). Between 2010 and 2050, the old age dependency ratio in Germany and Italy is expected to increase from 31.4 to 58.1 and from 31 to 56.3 respectively (1). In Belgium, the Netherlands and Finland, the age-dependency ratios are around the European average (26.7). In Iceland, at 18.9, the old-age dependency ratio is among the lowest in Europe (30).

Moreover, there will be an increasing number of frail and disabled older persons who need long-term care (2);(3);(4).

Table 1 shows that more than eight out of ten long-term care users in the home care setting are older than 65 years. In Belgium and Finland, this number is even almost nine out of ten.

Table 1: Macro indicators concerning the population across the participating IBenC countries (nk=information is not known)

	Belgium	Finland	Germany	Iceland	Italy	The Netherlands	Europe
POPULATION							
Total population[2] (persons)	11 161 642	5 426 674	80 523 746	321 857	59 685 227	16 779 575	501 468 333
Population density (inhabitant per km²)[3]	364.3	17.7	229	3.2	201.5	494.5	116.9
Old-age dependency	26.4	27.7	31.2	18.9	31.6	24.4	26.7

[2] The inhabitants on 1ste of January 2013 (Eurostat)
[3] Data from Eurostat for the population in 2011

	Belgium	Finland	Germany	Iceland	Italy	The Netherlands	Europe
ratio[4]							
Persons with long term care at home[5] **(% of the population)**	152 318 (1.4%)	70 529* (1.3%)	504 232 (0.6%)	nk	476 223 (1%)	610 180 (4.8%)	
Percentage of clients in long term home care who are 65+ years[5]	89.8%	89.8%	nk	nk	81%	81.3%	

* This includes the 'regular clients' with long term care in Finland. In the official statistics only those 1) with a care plan AND 2) with a visit minimum once a week are calculated as regular clients.

[4] This indicator is the ratio between the total number of elderly persons of an age when they are generally economically inactive (aged 65 and over) and the number of persons of working age (from 15 to 64). (Eurostat, update: 2012)

[5] From the EurHOMap project, 2012. As to Finland: http://www.thl.fi">THL, SOTKAnet Statistics and Indicator Bank 2005 - 2013

3.1.1 Euro Health Consumer Index

The Euro Health Consumer Index (EHCI) 2013 is the seventh study performed on European health care systems (19). The aim of the Euro Health Consumer Index is to select a limited number of indicators, within a limited number of evaluation areas, which in combination can present a good overview of how the healthcare consumer is being served by the different systems. The index does not take into account whether a national healthcare system is publicly or privately funded and/or operated. The consumer and patient perspective is central. The EHCI is focused neither on long term care, nor on home care. In this way, the EHCI 2013 consists of 48 indicators grouped in 6 sub-disciplines:

Sub-discipline	Number of indicators
Patient rights and information	12
Accessibility/Waiting time for treatment	6
Outcomes	7
Range and reach of services (“Generosity”)	8
Prevention	8
Pharmaceuticals	7

In 2013, all 28 European Union member states, plus Norway and Switzerland, Macedonia, Albania, Iceland and Serbia were involved in the EHCI. For this report, only the participating IBenC countries were included.

In

Table 2 the sub-disciples weighted scores, the overall score of the EHCI and the ranking score of the participating IBenC countries are summarised.

Table 2: Euro Health Consumer Index (2013)

Subscales	**Belgium**	**Finland**	**Germany**	**Iceland**	**Italy**	**The Netherlands**
Patient rights and information	92	117	125	125	104	142
Accessibility/Waiting time for treatment	225	125	200	150	138	188
Outcomes	179	226	202	250	179	226
Range and reach of services ("Generosity")	131	125	100	131	75	150
Prevention	99	99	78	104	99	89
Pharmaceuticals	71	81	90	57	57	76
TOTAL SCORE	797	773	796	818	651	870
RANK (all involved countries)	6	10	7	3	20	1

As

Table 2 shows, from a patient perspective, the Netherlands have the best healthcare system in Europe. With a total score of 870/1000, the Netherlands are first. However, of the 34 participating countries, 5 out of 6 IBenC countries are in the top 10. Only Italy scores lower, ranking twentieth. The EHCI 2013 report (19) argued that Italy provides healthcare services in which medical excellence can be found in many places. However, real excellence seems to depend too much on the clients' ability to afford private healthcare as a supplement to public healthcare.

For the IBenC project following especially the two indicators of the EHCI 2013 are interesting:

1. In the subscale 'Accessibility', the indicator 'Family doctor same day access' (see paragraph0)
2. In the subscale 'Range and reach of services', the indicator 'Equity of healthcare systems' (see paragraph 0)

3.1.2 Finances

The IBenC countries are wealthy countries, with the Netherlands being the wealthiest. The Gross Domestic Product (GDP) per head in these countries is higher than the European average, with the exception of Italy, where the GDP is about the European average (see Table 3).

The government expenditures (as % of the GDP) on health are approximately on the same level in all the IBenC countries (see Table 2). There is a range between 7% in Germany to 8.5 % in the Netherlands. In Germany the government expenditures on health are just below the European average (7% versus 7.3%), in all other countries the percentage is above average. Of these expenditures, only a small part is spent on long-term care at home, which on average is 0.53% of GDP in Europe. Finland and Belgium are above this average (0.70% and 0.60%), the Netherlands are at the average and Italy and Germany are below this European average (0.49% and 0.40%).

Table 3: Macro indicators concerning finances across the participating IBenC countries (nk=information is not known)

	Belgium	Finland	Germany	Iceland	Italy	The Netherlands	Europe
FINANCES							
GDP per capita in PPS index[6]	119	115	122	113	99	129	100
Government expenditures spent on Health, % of total government spending[7]	14.8	14.2	15.5	16.1	14.7	17.0	14.9
Government expenditures spent on Health (as % GDP)[8]	7.9	7.8	7.0	7.6	7.4	8.5	7.3
Government expenditures spent on Long term care(as% of GDP) [9]	2.35	2.51	1.43	nk	1.91	3.82	1.84
Government expenditures on Long term care at home (as% of GDP)[8]	0.60	0.70	0.40	nk	0.49	0.53	0.53

[6] Gross domestic product (GDP) is a measure for the economic activity. It is defined as the value of all goods and services produced less the value of any goods or services used in their creation. The volume index of GDP per capita in Purchasing Power Standards (PPS) is expressed in relation to the European Union (EU28) average set to equal 100. If the index of a country is higher than 100, this country's level of GDP per head is higher than the EU average and vice versa. (Eurostat, update: 2012)

[7] From Eurostat, 2011

[8] Government expenditure on Health in 2011, expressed in % of GDP. (Eurostat 2011)

[9] Data from commission services, 'Long term care: need, use and expenditure in the EU-27' Nov 2012. Long term care includes long term care at home, care in institutions and cash benefits. The data is based on data from 2010.

An interesting indicator of the European Health Care Index 2013 (19) is the the indicator 'Equity of healthcare systems' (part of the subscale 'Range and reach of services'). The equity of healthcare systems was measured by a single question 'What percentage (%) of the total healthcare spent is public?' The performance of the different national healthcare systems was graded on a three-level scale for each indicator, with the levels being green = good, amber =so-so and red = not-so-good. In this way, in a client's perspective, the scores on equity of the healthcare system are good for Iceland and the Netherlands. In the other IBenC countries the equity of health care systems is considered to be 'so-so' (see Table 4).

Table 4: The European Health Care Indicator 'Equity of healthcare systems' (2013)

	Belgium	**Finland**	**Germany**	**Iceland**	**Italy**	**The Netherlands**
Indicator: Equity of health care systems	So-so	So-so	So-so	Good	So-so	Good

3.1.3 Care professionals

Of the participating IBenC countries, the number of physicians (all specialities) per 1000 inhabitants is the highest in Italy (4.1) and the lowest in Belgium (2.9). Along with The Netherlands, Belgium also scores below the European average of 3.2 physicians per 1000 inhabitants. However, Belgium has the highest number of general practitioners (GP's) compared to the other IBenC countries. In Belgium there are 1.11 GP's per 1000 inhabitants, compared to 0.58 in Iceland (see Table 5).

Belgium also has the highest number of nurses per 1000 inhabitants. With 15.4 nurses per 1000 inhabitants, Belgium scores just above Iceland, with 14.8 nurses per 1000 inhabitants. Only Italy has fewer nurses than the European average, with 6.3 nurses versus 8.7 nurses per 1000 inhabitants.

Table 5: Macro indicators concerning care professionals across the participating IBenC countries (nk=information is not known). OECD Health data 2013, based on data from 2011.

	Belgium	Finland	Germany	Iceland	Italy	The Netherlands	Europe
CARE PROFESSIONALS							
Physicians per 1000 inhabitants[10]	2.9	3.7	3.7	3.5	4.1	3.0	3.2
GP's per 1000 inhabitants	1.11	nk	0.66	0.58	0.76	0.73	
Nurses per 1000 inhabitants[11]	15.4	9.6	11.4	14.8	6.3	11.8	8.7
Professionally active caring personnel per 1000 inhabitants[12]	6.91	25.2	nk	nk	7.74	18.42	

[10] From OECD Health data 2013, based on data from 2011. The data for Finland are derived from the Finnish Medical Association http://www.laakariliitto.fi/tutkimus/laakarityovoima/ in 2013. In Belgium, Germany, Iceland and Italy the data refer to practising physicians. Practising physicians are defined as those providing care directly to patients. In the Netherlands the data refer to professionally active physicians. They include active physicians plus other physicians working in the health sector as managers, educators, researchers, etc. (adding another 5-10% of doctors).

[11] From OECD Health data 2013, based on data from 2011 (except for The Netherlands where the data is based on data from 2010). The figures for Finland are from 2013 and derived from the Finnish Nurses Association http://www.sairaanhoitajaliitto.fi/viestinta/tilastoja/.
In Germany and Iceland the data refer to active nurses active in health care, those providing care directly to patients. In the Netherlands and Italy the data refer to professionally active nurses. They include nurses active in health care plus other nurses working in the health sector as managers, educators, researchers, etc. (adding another 5-10% of nurses). In Belgium the data refer to all nurses who are licensed to practice. The OECD average counts 8.7 nurses per 1000 inhabitants.

[12] From OECD Health data 2013, based on data from 2011 (except the Netherlands and Finland where the data is based on data from 2010) Professionally active caring personnel include caring personnel professionally active in care and other caring personnel for whom their education is a prerequisite for the execution of the job. Caring personnel active in care includes both health care assistants (nursing aide, patients care assistant, psychiatric aide, foreign health care assistants practicing in the country) in institutions and home-based personal care workers (home care aide, nursing aide, personal care provider and foreign personal care workers practicing in the country). Other caring personnel includes caring personnel working in administration, management, research and in other post exclude direct contact with patients.

However, Belgium has the lowest number of professionally active caring personnel. Professionally active caring personnel include caring personnel professionally active in the caring sector and other caring personnel for whom their education is a prerequisite for the execution of the job. Caring personnel active in the caring sector includes both health care assistants (nursing aide, patients care assistant, psychiatric aide, foreign health care assistants practicing in the country) in institutions and home-based personal care workers (home care aide, nursing aide, personal care provider and foreign personal care workers practicing in the country). Other caring personnel includes caring personnel working in administration, management, research and in other post exclude direct contact with patients (OECD, 2013). Finland and the Netherlands have the highest number of professionally active caring personnel per 1000 inhabitants (respectively 25.2 and 18.42). Italy counts 7.74 professionally active caring personnel per 1000 inhabitants and Belgium 6.91.

The European Health Care Index 2013 indicator 'Family doctor same day access' measures whether clients count on seeing a primary care doctor on same the day of their request to visit or be visited by this doctor. The question to be answered was: "Can your country's patients see their primary-care doctor that same day (with or without an appointment)?"(19). The performance of the different national healthcare systems was measured with a three-level scale for each indicator, with the levels being green = good, amber =so-so and red = not-so-good. The scores for the participating IBenC countries are summarised in Table 6. Belgium, Germany, Italy and The Netherlands score good on the indicator 'Family doctor same day access'. Finland and Iceland score not-so-good.

Table 6: The European Health Care Indicator 'Family doctor same day access' (2013)

	Belgium	**Finland**	**Germany**	**Iceland**	**Italy**	**The Netherlands**
Indicator: Family doctor same day access	Good	Not-so-good	Good	Not-so-good	Good	Good

The EHCI 2013 report (19) concluded that the responses on this indicator show that there is no explanation for waiting times in primary care, there is no correlation with financial matters (GDP or healthcare spend per capita), nor with the range of services provided, or the density of the primary care network (including the number of GP's per 1000 inhabitants).

3.1.4 The vision about best care option for elderly parents according to the population

Between the 25th of May and the 30th of June 2007, TNS Opinion & Social interviewed 28,660 Europeans aged 15 and over, living in the 27 European Union Member States and two candidate countries Croatia and Turkey (16). Table 7 shows the results concerning the vision on best care for the elderly in five participating IBenC-countries (Iceland was not included in the study). The vision on the best care option for the elderly according to the population was conceptualised by the following three questions:

1. '*Imagine an elderly father or mother who lives alone and can no longer manage to live without regular help because of her or his physical or mental health condition. In your opinion, what would be the best option for people in this situation? Firstly?'*
    a. With response categories:
        (1) 'They should live with one of their children'
        (2) 'Public or private service providers should visit their home and provide them with appropriate help and care'
        (3) 'One of their children should regularly visit their home, in order to provide them with the necessary care'
        (4) 'They should move to a nursing home'
        (5) 'It depends (spontaneous)'
        (6) 'None of these (spontaneous)'

2. Please tell me to what extent you agree or disagree with the following statement: '*Public authorities should provide appropriate home care and \ or institutional care for elderly people in need'*
    a. With response categories:
        (1) Totally agree
        (2) Tend to agree
        (3) Tend to disagree
        (4) Totally disagree

    The response categories 'totally agree' and 'tend to agree' are combined into the category 'Agree'; 'tend to disagree' and 'totally disagree' are merged into 'Disagree'.

3. Please tell me to what extent you agree or disagree with the following statement *'Care should be provided by close relatives of the depended person, even if that means that they have to sacrifice their career to some extent. '*
    a. With response categories:
        (1) Totally agree
        (2) Tend to agree
        (3) Tend to disagree
        (4) Totally disagree

    The response categories 'totally agree' and 'tend to agree' are combined into the category 'Agree'; 'tend to disagree' and 'totally disagree' are merged into 'Disagree'.

In this way, the vision on the best care option for elderly parents according to the population is summarised in Table 7.

Table 7: The vision about the care option for elderly parents according to the population (Eurobarometer, 2007)

Imagine an elderly father or mother who lives alone and can no longer manage to live without regular help because of her or his physical or mental health condition? In your opinion, what would be the best option for people in this situation? Firstly?							
	Belgium (n=1040)	**Finland** (n=1026)	**Germany** (n=1510)	**Iceland**	**Italy** (n=1017)	**The Netherlands** (n=1001)	**Europe** (n=26659)
% respondents on 'They should live with one of their children'	17	7	25	nk	28	4	30
% respondents on 'Public or private service providers should visit their home and provide them with appropriate help and care'	38	51	27	nk	30	52	27
% respondents on 'One of their children should regularly visit their home, in order to provide them with the necessary care'	22	25	30	nk	22	20	24
% respondents on 'They should move to a nursing home'	19	13	8	nk	7	18	10
Public authorities should provide appropriate home care and \ or institutional care for elderly people in need							
% respondents agree with the opinion	97	99	91	nk	88	96	93
Care should be provided by close relatives of the depended person, even if that means that they have to sacrifice their career to some extent.							
% respondents agree with the opinion	25	20	35	nk	48	13	37

In all countries, nine out of ten up to almost all respondents agreed with the statement 'Public authorities should provide appropriate home care and / or institutional care for elderly people in need'. Even more, the common opinion in the IBenC countries (except in Germany) about the best care option for 'parents who live alone and can no longer manage to live without regular help', is 'Public or private service providers should visit their home and provide them with appropriate help and care'. In Belgium, the Netherlands and Finland, people think the second best option for those elderly is 'One of their children should regularly visit their home, in order to provide them with the necessary care'. In Germany these two options are given in reversed order. The second best option according to the population for those elderly in Italy is 'They should live with one of their children'.

The opinions are equally explicit in all the countries. Half of the Dutch population (52%) and half of the Finnish population (51%) state that the best option for these elder people is that the 'Public or private service providers should visit their home and provide them with appropriate help and care'. However, in Belgium, Germany and Italy, only around one third of the population agrees with that option (respectively 38%, 27% and 30%). The option 'They should live with one of their children', is given more often in Italy and Germany, compared to the Netherlands and Finland (28% and 25% versus 4% and 7%). The option 'They should move to a nursing home' is only indicated by a low percentage of respondents in Italy and Germany. With 7% in Italy and 8% in Germany, both countries score below the European average of 10%.

In short, the opinion that children need to take care of their frail elder parents is more explicit in Italy and Germany. In Italy 48% and in Germany 35% of the population agreed with the statement 'Care should be provided by close relatives of the depended person, even if that means that they have to sacrifice their career to some extent.' This is a more explicit opinion compared to Belgium, Finland and the Netherlands (25%, 20% and 13%).

3.2 Description of the home care system

In the following six paragraphs (3.2.1 to 3.2.2), the home care systems of all IBenC countries are described. The information on the home care system is based on case studies, written during the EurHOMap-project (Home Care across Europe. Current structure and future challenges). The EurHOMap project was funded by European Observatory on Health Systems and Policies, a partnership hosted by the World Health Organisation 2012 (19);(25)-(30).

After the EurHOMap information was summarised, the IBenC person responsible for each IBenC country, who is well acquainted with the home care system in his or her own country, was asked to check the information, bearing in mind the following questions:

1. Is the information in the document correct?
2. Is the information sufficiently detailed? If not, please add the information you think is missing.
3. Is the information up to date or do you have more recent information?
4. Are there things that should be added because the region(s) included for the IBenC project have specific characteristics or regulations?

In this way, updated country specific descriptions on the home care systems were developed for the IBenC project.

The definitions used in this description are:

- Home care: care provided at home by professionals. Care means domestic aid services, personal care and supportive, technical and rehabilitative nursing. The three subgroups are described below.
    - Nursing care: activities of nurses that are of a technical, supportive or rehabilitative nature.
    - Personal care: providing assistance with dressing, feeding, washing and toileting and getting in or out of bed.
    - Domestic care: help with instrumental activities of daily living (IADL), such as shopping, food preparation, housekeeping, transportation, taking medication and financial administration.

3.2.1 Home care system in Belgium

Belgium: structure	
Belgium is a Federal parliamentary constitutional monarchy. It is spread over Flanders, Wallonia and Brussels Capital Region. Belgium is also divided in communities: French speaking community, Flemish speaking community, German speaking community and Brussels common community commission. In the IBenC project only organisations of Flanders (or the Flemish speaking community) will participate. This table only include information apply for Flanders.	
Vision of home care	
The intention of the federal government is to stimulate home care, invest in affordable formal care and good coordination between care providers. Also arrangements for the support of informal caregivers should be developed. The main policy document in Flanders (Home Care Decree) sees home care (excluding care provided by nurses) as a supportive instrument to enable clients to stay in their home environment. In a later decree (Care and Living Decree) a more integrative vision on home care is described. It aims to integrate care pathways and promote flexibility between self-care, informal care, home- and residential care; to increase quality of care and to increase financial accessibility.	
Regulation on home care	
Home care responsibilities are shared between the federal government and the communities. The different communities have divergent home care systems and their own policy. In this way there exist important differences in professional resources and availability of health and social institutions.	
Nursing + Personal care	Home care provided by nurses is mainly a federal affair. Home nursing refers to personal care and technical nursing provided by qualified nurses and nursing assistants.
Family care: Personal + Domestic care	Family care is mainly a community affair. Family care refers to personal care and domestic aid provided by non-nursing professionals. A major priority of the Flemish government on personal and domestic care is to expand services, i.e. number of hours, geographical dispersion, number of service centres and availability of palliative care at home.
Logistic home care: Domestic care	Logistic home care is mainly a community affair. Logistic home care consist of cleaning assistance and simple housing work such as small painting and sitting service and some general psychological support.
Technical aids	Technical appliance e.g. wheelchairs or special beds can be received through the Insurance Funds (Mutualities) and the regional services centres.
Eligibility for home care services	
Nursing + Personal care	Eligibility criteria for public funding are set by the National Institute for Health and Disability Insurance (NIHDI). To receive care provided by nurses, a certain level of ADL dependency (measured by the Index of ADL) is required or a doctor's referral in case of specific technical nursing activities and a number of specific conditions.

Family care: Personal and domestic care	According to the Flemish regulations, family care should be delivered in those cases where the capacity of a person is insufficient due to mental or physical disabilities or due to social circumstances (measured by a community level form). Priority should be based on the needs, the self-care ability and the availability of informal care. It is up to the providers to set the exact priority groups in accordance with the law.
Freedom of choice of care provider	
Theoretically, people are free to choose their home care provider. The free choice of home care providers is hampered by lack of information among care seekers and referral agents, which results from affiliations of agencies to mutualities.	
Provision of home care	
Type of organisation	Nursing care in Flanders is delivered by not-for-profit umbrella organisations mostly linked to the mutuality (insurance fund) of the client and by self-employed nurses or associations of private nurses. It is estimated that half of the nursing care is provided by self-employed/independent nurses. Family care (personal and domestic care) can be provided by Public centres for Social welfare or by private providers.
Care professionals	• The professionals for nursing care are care experts (one additional year of secondary school) and qualified and certified nurses (respectively 3 years vocational training and 3 years bachelor education). • The professionals for personal care are care experts, qualified and certified nurses and carers (secondary education or one-year training after secondary school). • The professionals for domestic care are carers and cleaning assistants (no educational requirements).
Coordination and integration	To apply for care; the person in need, their family or a third person (e.g. GP) needs to contact a home care organisation. Most of all the clients and their family contact directly the organisation or their mutuality (sickness insurance organisation). For technical nursing care, a doctoral referral is needed. Staff of the organisation or a nurse will perform an individual needs assessment. After assessment, a care plan is made. Several subsidised initiative have been taken to integrate home care services. Nevertheless, coordination is seen as problematic.
Funding of home care	
Nursing + Personal care	Home nursing is funded by the national obligatory health insurance premiums, membership fees, client co-payments and optional voluntary insurances. It is also co-financed by the federal social insurance.
Family and logistic care: Personal + Domestic care	Family and logistic home care are mainly financed through community taxation and client co-payments. It is also co-financed by the communities and the municipalities.

Technical aids	The National Institute for Health and Disability Insurance (NIHDI) finances technical appliances.
Co-payment	
Nursing + Personal care	Co-payments depend on income, age and disability level. Co-payments generally are about 25% of the total nursing care costs. No client co-payments are needed in the cost for healthcare financed by the National Institute for Health and Disability Insurance for widowers/widows, people with disabilities, orphans and pensioners.
Family care: Personal + domestic care	Criteria for reductions in co-payment are set by the Flemish community and the municipalities. The clients pay providers themselves either through co-payment or through services cheques.
Logistic home care: domestic care	Domestic aid such as cleaning assistance and meals on wheels can be purchased by means of services cheques. Services cheques can be spent on services provided by federally recognised 'services cheques' enterprises.
Reimbursement	
Nursing + Personal care	NIHDI reimburse all services that are performed by nurses.
Family care: Personal + domestic care	Monthly obligatory cash benefits for family care received from the Flemish Care Insurance cover a part of the client's co-payments. Requirements for this are: a need of long-term care and severe disabilities (measured with standardised instruments). Domestic aid and personal care provided by a personal assistant can be paid from a client's 'Personal Assistance Budget'. This option is applicable for people under 65 years with disabilities.
Logistic home care	The services cheques are partly funded by the federal government and partly paid by the client.
Technical aids	The cost of renting and buying technical appliances can be (partly) financed through the Flemish Care Insurance under the same requirements as family care (long-term care and severe disabilities). Also the compulsory health insurance partly reimburses technical aids. People under 65 years with disabilities, can ask a compensation to the Flemish agency for Persons with Disabilities ('Vlaams Agentschap voor Personen met een Handicap').
Informal care	In Flanders, formal support of informal caregivers is available such as respite care, courses on home care and dementia and supervisory care when a caregiver is temporarily absent. In case of palliative care and care for a very ill family member, a career break can be taken while receiving monthly career break compensation.

Quality of home care	
Nursing + Personal care	Quality control on home nursing financed by the NIHIDI is practically absent. In Flanders, as stated in the Flemish Quality degree, every two years nursing care providers must self-evaluate the process, structure and outcome of care, including an assessment of the client's satisfaction. This is not applicable for the independent nurses.
Family care: Personal + domestic care	In Flanders, some regulation has been developed with regards to the quality of family care. Registration implies that providers must adhere to norms on the process of care. Quality within family care consists of having a quality handbook, self-evaluation, a quality plan and writing an annual report. There is an external inspection by the Flemish Agency for Care and Health. Additionally, as stated in the Flemish Quality degree, every two years providers must self-evaluate the process, structure and outcome of care, including an assessment of the client's satisfaction.

EurHOMap reference: Naiditch Michel, Genet Nadine & Boerma Wienke, '*Home Care across Europe-Case studies. Belgium*. EurHOMap. The European Observatory on Health Systems and Policies. A partnership hosted by the WHO. 2012

3.2.2 Home care system in Finland

FINLAND: structure	
Finland is a parliamentary republic and was divided into 320 municipalities (beginning of 2013). Finland has an extremely low population density, especially in the North and East. The areas included for the IBenC study are Eksote, Kainuu, Oulu, and potentially Helsinki.	
Vision of home care	
The national government aims to enable elderly people to live at home as long as possible and to stay in their own social environment. Central theme is to safeguard a good quality of life, self-determination and independence. Also quality of care has come high on the policy agenda.	
Regulation on home care	
Governmental responsibilities are constitutionally strongly decentralised. Municipalities, who are primarily responsible for organising social, and health care for the population, are also responsible for home care. By legislation, home help and home nursing belong under different acts. However, the Ministry of Social Affairs and Health encourages the local authorities to combine the health and social work in the field of home care. Many smaller municipalities cooperate with other municipalities to deliver home nursing care and home help services. The national government holds its supervisory role mainly by law and information steering, the practical work of supervision is performed by governmental organ called '*National Supervisory authority for Welfare and Health (Valvira)'* and '*Regional State Administrative Agencies'*. The most important laws concerning home care are: (1) Act on Supporting the Functional Capacity of the Older Population and on Social and Health Care Services for Older Persons, launched 1^{rst} of July 2013 (980 /2012), that highlights home as primary place for living. This new legislation, in short "elderly care act", obliges municipalities to develop a municipal policy and service plan for care for older people. (2) The Social Welfare Act, (3) the Primary Health Care Act and (4) the Act on the Status and rights of Social Welfare Clients.	
Nursing care	Home nursing is performed by nurses and it encompasses taking care of illness, medicines, nursing rehabilitation and performing procedures such as wound. It also includes preventive care. Nurses are responsible for greatest part of the personal care, such as helping with daily activities
Home help: domestic care	Home help consists of helping in daily activities (performed by nurses), domestic help and personal care (supportive services such as meals –on-wheels, cleaning, bathing, shopping, and personal alarm system).
Eligibility for home care services	
The municipalities are free to decide about eligibility. Availability, scope, structure and quality of services vary substantially from one municipality to another as well as between units of provision. However, social and health care benefits do not depend on the financial situation or the availability of informal care. Eligibility criteria usually relate to medical history, the physical, mental and psycho-social impairments, the possibilities of ADL and the social environment.	
Nursing care	For home nursing a physician's referral is required. It may originate hospital or health centre, and needs to be approved by health centre physician

Home help: Personal + domestic care	Home help is generally meant for clients who need support in routine daily activities due to, illness, trauma or other handicap. It can be also delivered to children.
Freedom of choice of care provider	
Nursing care + Home help	Service vouchers allow clients to purchase care services under their own conditions from whomever they wish. However, service vouchers are not available everywhere and only to a limited extent. Furthermore, two acts formalises the rights of the clients or patients in health and social care (Act on Status and Rights of Social Welfare Clients and the Act on Status and Rights of Patients). For example, the Act on Status and Rights of Social Welfare Clients support the idea that the wishes of clients must be taken into account in the planning and provision of social welfare services. Although dependent persons are in principle free to choose their provider, in practice this choice is hampered in several ways. Private providers are not always available in many municipalities and private providers are free to decline a care request from the patient.
Provision of home care	
Type of organisation	The organizations are mainly municipal (public) home help and home nursing services. Private services and partnerships between public, private and third sector have become the accepted solution for the increasing demand of care. Self-employment is still infrequent. NGOs and voluntary organizations are also involved in the delivery of home help and assistance.
Care professionals	• The professionals for nursing care are primary nurses and specialised nurses. (3.5 - 4.5 years education). • The professionals for personal care are (1) licensed practical nurses with 2-3 years training (second level training) (2) home care assistants (1.5-3 years education) and (3) care aides (1 year education). Municipalities can independently decide upon job description. Whether nursing care is required, simple personal care is provided by a nurse too. • The professionals for domestic care are housekeepers and care aides (1 year training). • Social workers perform preventative home visits and coordinate care and transfers from hospital to home (master degree). They assist the clients with applying various subsidies and non-acute intermediate care (Care aide. A new profession initiated in 2011, first professionals graduated 2012. Training (1 year) consists of parts of a training of licensed practical nurse. Job description includes domestic care tasks and personal care, however magnitude of the latter is under discussions.)
Coordination and integration	Of the 189 municipalities or joint groups of municipalities, 163 (84.2%) organised either health check-ups or preventive home visits for aged population, in 2013. The new elderly care act obliges the municipalities to offer health examinations, appointments and home visits that support wellbeing, health, functional capacity and independent living in particular for those members of the older population whose living conditions and life situations are on the basis of

	research results or general life experience considered to involve risk factors increasing their need for services. Time will show whether the preventive home visits or guidance becomes a part of standard home care or not. Nevertheless, the services must include: (1) guidance aiming to promote wellbeing, healthy lifestyles and functional capacity as well as to prevent illness, accident injuries and accidents; (2) identification of any social and health problems caused by the impaired health and functional capacity of the older population, and provision of early support related to that; (3) guidance regarding social welfare and other social security; (4) guidance regarding medical care, multiprofessional rehabilitation and safe pharmacotherapy; and (5) guidance for using the services promoting wellbeing, health, functional capacity and independent living available in the municipality Publicly provided home care organisations are contacted by the hospital, the client, their family, the GP or by other primary care providers. The municipalities then organise an assessment visit where they will use a standard form to assess the care needs. Those wanting a private organisation usually find providers by advertisements or are informed about them by the municipality. Integration between home help and home nursing is encouraged by the Ministry of Social Affairs and Health. Municipalities increasingly work with teams of home helps and home nurses for designated geographical areas. Coordination between hospitals and public home care services is quite often well developed. Home hospitals usually work in close cooperation with night teams of the home nursing providers. And home care providers also often provide care in service homes, elderly homes and nursing homes.
Funding of home care	
Health services funded by	The main sources are municipal (local) and national taxation. The municipalities receive resources from the government but the larger part is funded by local taxation. The compulsory health insurance funds 'care allowances' for elderly and severely disabled persons. Also private payments are an important source of funding (full-payment or co-payment). Private providers are usually paid directly by clients (out-of-pocket or with vouchers).
Co-payment	
The home care clients who receive public home care need to co-pay. The magnitude of co-payment depends on local authorities, and the financial position of the client. Usually maximum co-payment has a defined ceiling. Nevertheless, home care clients are in unequal position as to their co-payments, and regarding the care they receive, depending on where they live. Private providers or self-employed individuals can be paid with vouchers that clients received from the municipality. The vouchers are means-tested and they are bound to a maximum per month. As the value of the service vouchers is not enough to buy services, co-payment by client is required.	
Technical aids	Technical aids can be borrowed by elderly persons from their health centre or from the hospitals.

Reimbursement	
There are some means-tested allowances for pensioners and people with disabilities to cover part of dependency costs. 'KELA', the Social Insurance Institute of Finland offering home care allowances. Such allowances required a referral by a physician and the illness or injury should have resulted in a (at least weekly) assistance, guidance or supervision with personal activities of daily living or in continuous expenditures at least equal to a certain amount. The allowances can be used to cover costs for public or private home help and home nursing. Additionally there are vouchers that clients received from the municipality. The vouchers are means-tested and they are bound to a maximum per month.	
Informal care	Informal care is a legislation-based concept, where care giving is supported by municipal support system through cash and in-kind benefits. In 2014 the minimum benefit will be 381 € per month. A person with official informal caregiver can also receive home care. Financial compensation for informal caregivers does not exist in the form of home care allowance.
Quality of home care	
In 2008, the Association of Finnish Local and regional Authorities and the Ministry of Social affairs and Health have updated a framework for the quality of care for elderly in 2013. It is intended to be used by providers and decision makers to develop and monitor the quality of their services. It contains values, ethical principles and strategies that increase the quality and effectiveness, but it does not include quality criteria. Municipalities are responsible to organise the quality of care. Of the municipalities, approximately one fourth used interRAI systems to monitor quality of their home-care in 2012.	

References:

- EurHOMap reference: Genet Nadine, Boerma Winke & Rissanen Sari, '*Home Care across Europe-Case studies. Finland*. EurHOMap. The European Observatory on Health Systems and Policies. A partnership hosted by the WHO. 2012
- National Institute for Health and Welfare: Sotkanet (http://uusi.sotkanet.fi/portal/page/portal/etusivu) and vanhuspalvelulain toimeenpanon seuranta (http://www.thl.fi/fi_FI/web/fi/aiheet/tietopaketit/vanhuspalvelulain_toimeenpanon_seuranta)
- Ministry of Social Affairs and Health (www.stm.fi)

3.2.3 Home Care system in Germany

Germany: structure	
Germany is a federal parliamentary republic	
Vision of home care	
In Germany, everyone ought to stay at home for as long as possible, but the benefits provided by the long-term care insurance are not supporting the principle. A new care extension law (Pflege-Weiterentwicklungsgesetz) introduces a gradual increase of benefits for home care. The official policy counts on care-giving relatives in home care. The newly introduced update of the social insurance for care aims further improvement of the situation of family caregivers. This new law (2008) also aims at more continuity and intensified care and case management.	
Regulation on home care	
Nursing care	Home nursing belongs to the health sector and the Health Care Insurance is responsible for it. Around 51 million Germans are members of statutory health care insurance required by law. Additionally, 11% of the population has a private insurance. Only 211 000 individuals did not have any health insurance in 2007.
Personal and domestic care (home care)	Home care belongs to the long-term care and the long term care insurance is responsible for it. Long-term care represents a separate pillar of the care system. A special insurance (social care insurance - sociale Pflegeversicherung) is responsible for the allocation and reimbursement of long-term care in institutions or in the community. This home care consists of ADL care, a certain part of IADL care, some basis nursing care and light supervision of simple medication.
Eligibility for home care services	
Nursing care	Eligibility for home nursing care is inseparably connected to 'need for treatment' out of hospital. A prescription by a GP or another physician is required and possible if the home nursing makes medical treatment at home possible and helps to shorten the hospital stay.
Personal and domestic (home care)	Members of the long-term care insurance (or their dependents) are eligible for benefits if they are currently unable to fulfil basic ADL (or some IADL) functions for at least six months.
Technical care	Insured individuals (of the Health Care Insurance) can receive technical aids when the following requirements are met: a medical prescription; the devices are needed directly for the treatment or prevention of an illness and the allocation of the devices must be reasonable from an economic point of view.

Freedom of choice of care provider	
The Charter of Rights for people in Need of Long-term Care and Assistance is intended to strengthen the role and the legal position of long-term care users and their relatives.	
Provision of home care	
Type of organisation	The existing home care organisations mainly provide both home nursing and home care. Most of the organisations (57.6 %) are owned by private organisations that are working for profit; 40.6% are owned by charity organisations and 1.8% by public institutions. Most of the private organisations are very small, with a median of 18 served clients per organisation.
Care professionals	The professionals providing nursing care are qualified nurses. The professionals providing personal care are fully qualified nurses for the aged. The professionals providing domestic care are home-helpers (training of 3 months to one year).
Coordination and integration	The division between home nursing and home care (personal + domestic care and basic nursing activities) has negative effects on the continuity of care. The GP's/physicians or the local and regional Medical Services of the Health Insurance Institutions (MDK) often do not recognise that persons who need long term care, often also need nursing care. So the level of integration is low in Germany.
Funding of home care	
Health services funded by	Health services are funded by the public budget (states and communities); the statutory health insurance; the statutory long-term care institutions; private insurance and the private households. Co-payments are required as the long-term care insurance benefits are generally insufficient to cover home care costs.
Nursing, personal care and domestic care	The main income of the agencies comes from the selling of care and other services to their clients. The federal ministry on health is authorized to set a price for long-term care at home.
Co-payment	
Personal and domestic care	Co-payments are required as the long-term care insurance benefits are generally insufficient to cover home care costs.
Technical aids	Technical devices require a co-payment of 10% up to 25euro. Consumables are covered by long-term care insurance for up to 31 euro per month; the client must pay costs above this amount.

Reimbursement	
Personal care and domestic care	The insurance institutions reimburse the expenses for individual cases. Therefore a person has to send her/his application to the long-term care insurance institution. These documents are evaluated by local and regional Medical Services of the Health Insurance Institutions (MDK) that visits the person at home. The long-term care insurance is responsible for the final decision.
Informal care	Care-giving relatives can receive benefits in money; can follow courses in care giving and use counselling free of charge; can increase the retirement benefits. The caregivers may 'leave from work' for up to 6 months, bur salary and payment stops during the leaving.
Quality of home care	
Personal and domestic care (Home care)	The long-term care insurance law offers a general regulation of quality management and quality assurance. The Medical Services of the Leading Organisation of Health Funds is responsible for the development of the concept and its implementation. This is the most important consultant of the Health funds on the quality issue. On local and regional level the Medical Services of the Health Insurance Institutions (MDK) is in charge. Care providers are obliged to introduce an internal quality assurance in their agencies. The MDK examines whether the requirements are fulfilled, this with the purpose of the quality of life of clients.

EurHOMap reference: Vjenka Garms-homolovà, '*Home Care across Europe- Case studies. Germany*. EurHOMap. The European Observatory on Health Systems and Policies.a partnership hosted by the WHO. 2012

3.2.4 Home Care system in Iceland

ICELAND: structure	
Iceland is a unitary parliamentary constitutional republic. It has the lowest population density of Europe. There are only two urban areas in the country and a significant proportion of the population lives in isolated communities. The area included for the IBenC study is the capital of the country, Reykjavík.	
Vision of home care	
There is the intention of improving integration between home nursing and social care services, improving 24-hour coverage and seeking best use of resources. There has been a strong national policy and practice shift to place people according their need. The introduction of residential eligibility criteria by the government has increased pressure on home care services.	
Regulation on home care	
Two governmental departments take the major responsibility for home care in Iceland: The Ministry of Social affairs and Social Security and the Ministry of Health. A Joint committee on the Affairs of the elderly brings together policymakers from the two ministries, the senior Citizens and the Union of Local Authorities, under the working of the Act on the Affairs of the Elderly (1999). This Act is the main policy instrument for the care of older people. It indicates an active consideration of the challenges of an aging population. Home nursing services and social care services are increasingly being managed by municipalities. Health centres that also provide home nursing are managed by the Ministry of Health. The move is towards increasing integration of nursing and domestic care.	
Eligibility for home care services	
Nursing care	Needs assessments for home nursing is assessed by home nursing staff who work from health centres or by nurses who are employed by the municipalities. There is a subjective (no formal or structured) assessment process. Prescription by GP or another physician is mostly required for such things as medication and oxygen treatment. All nursing care is planned by the nurses and they are rather independent in their work.
Domestic care	Eligibility for domestic aid support is established by members of Municipalities Social Services departments and these criteria may vary between municipalities and are depended on the availability of funds.
Freedom of choice of care provider	
Nursing and domestic care	There is some choice of provider in the larger communities, but this is more limited elsewhere because of the small size of the market.
Provision of home care	
Type of organisation	Health centres and their staffing (GPs, health centre nurses and some home nurses) are paid by the Ministry of Health. Not-for-profit organisations provide home nursing services and domestic aid services, paid from the municipalities. There are a few for-profit agencies. There is no real commercial incentive.

Care professionals	• The professionals for nursing care are community nurses (4 years university course with a specialization in community nursing). • The professionals for personal care are health care assistants. • The professionals for domestic care are home help staff.
Coordination and integration	Care for the older people with problems of frailty, physical or mental illness is usually managed by partnership of social services, home nursing and primary care teams in the health centres. Respite care, day care and day centres are closely integrated with the home care services because much of the management responsibility of all those services falls to the municipalities.
Funding of home care	
Health services funded by	Health services are funded through general taxation. The Ministry of Health pays the organisations (health centres, not-for-profit and private organisation) that provided care through direct payments. There is also an element of co-payment for primary care and social care provision.
Nursing care	State funding is the main basis for financial support of home nursing providers.
Co-payment	
Co-payments are means-tested and tend to apply to social care costs such as home helps, Day Centres and for a range of primary health care services, including visits to a GP or GP visits to the home. It is means-tested for those on lowest income.	
Reimbursement	
It is possible to obtain a Personal Budget, but this happens relatively infrequently (mainly a service used by younger people who have disabilities).	
Informal care	Financial compensation may be available if a spouse has suffered a loss of income as a result of stopping full-time employment to provide care at home.
Quality of home care	
Recently the interRAI-HC assessment was introduced for clients who are 80 years or older. The interRAI-HC assessment gives 20 quality indicators, 7 of them are published in the annual report. Additionally there is a clients' survey concerning their view on service delivered.	

EurHOMap reference: Hutchinson Allen, '*Home Care across Europe- Case studies. Iceland*. EurHOMap. The European Observatory on Health Systems and Policies. A partnership hosted by the WHO. 2012

3.2.5 Home Care system in Italy

Italy: structure	
Italy is a democratic republic. It is divided in 20 regions and each region is divided in provinces. The area included for the IBenC study are located in central (Umbria region) and Northern (Lombardia region) Italy.	
Vision of home care	
A law (833/1978) stated the importance of preventing elderly isolation and home care has been an official policy. The National Health Plan since 1998-2000 and the Legislative Decree 229/1999 aimed envisaged an integrated home care scheme. Law 328/2000 aimed at promoting integrated health-social home care. Care for the older people is felt to be a social duty for families.	
Regulation on home care	
Nursing care	The main ministry for home nursing is the Ministry of Health. Home nursing care includes the home nursing service, home hospitalisation service, patient control analgesia and programmed home care assistance by GP's.
Home help: Personal + domestic care	The main ministry for home help is the Ministry of Work and Social Policy. Home help includes housework, personal care and social home care.
Eligibility for home care services	
Nursing care	There are uniform eligibility criteria: home nursing is needs-tested and the availability of informal cares is taken into account. The GP is the care professional in charge for deciding whether a client needs home health care. Subsequently a multidimensional evaluation is performed by multiprofessional units within the local health authorities.
Home help: Personal + domestic care	Home help is means-tested and needs-tested (by a GP's certificate assessing). In the absence of national/regional guidelines, municipalities define their own criteria of eligibility.
Technical aid	Depends of the civil disability level (by a GP's certificate assessing).
Freedom of choice of care provider	
Nursing care + Home help	In several regions only, clients can choose among accredited suppliers through vouchers. With regard to support for making a decision, Service Charts of the providers indicate the organisation and the characteristics of the services supplied. The choice for services mainly comes from physicians and nurses, less from social services.
Provision of home care	
Type of organisation	Most of the organisations are for non-profit. Private paid home social care and private home nurses are an informal market and often out of public regulations.

Care professionals	• The professionals providing nursing care are nurses (university courses). • The professionals providing personal and domestic care (home help) are social-sanitary operators and private home assistants (1000 hours training course after secondary school); social workers and professional educators (three years of education).
Coordination and integration	Usually home help and home nursing are provided by different organisations. It should be noted that although a law aimed promoting an integrated system of services, many regions still haven't set the rules for organisational and financial integration. However, the regions involved in the IBenC project (Umbria region and Lombardia region), are well organised with the integrated systems.
Funding of home care	
Health services funded by	The National Health Service is financed by 95% through direct taxation (on income) and indirect taxation (on consumption). The National Health Fund is divided among regions and Local Health Authorities. The remaining costs are covered by revenues of Local Health Authorities and client co-payment. The Italian care system is mainly cash-oriented through disability/invalidity pensions, attendance allowance and care allowances.
Nursing care	Local Health Authorities
Home help: Personal + domestic care	Regions (through funds from the National Health Fund) and municipalities (through regions).
Technical aid	Local Health Authorities
Co-payment	
Nursing care	The client co-payments are related to age, income, disease and phase of cure. Home nursing is free of charge for all older people meeting eligibility criteria.
Home help: personal and domestic	There is a means-tested co-payment by clients for home help. Only for those with a high income co-payment is necessary.
Technical aids	Co-payment is taken into consideration the civil disability level. It is free for people with a disability of more than 34%. In case a technical aid is not included in the list provided in the ministerial decree, co-payment is also necessary.
Reimbursement	
Nursing care	Not applicable
Home help: Personal + domestic care	Not applicable

Informal care	Care allowances (financed by the municipalities or sometimes by the Local Health Authorities) are used to pay family members for informal care. The client is free to spend the allowance as desired. Additionally there are measures for working caregivers (flexible working times, paid/unpaid care leaves) and deductions from income tax. Informal caregivers are considered as co-clients with needs to be taken into account. Measures for supporting family caregivers include day-centres, self-help groups, relief /respite services.
Quality of home care	
Nursing care + home help	Rules on Quality Management describe elements for managing and set the quality of the integrated home care. Also the regulations of integrated social-health home care and home help sometimes contain references to quality assurance. Nevertheless, the evaluation of the results and the recording of operational data are little practiced in Italy.

EurHOMap reference: Melchiorre M-G, Greco C., Lucchetti M., Chiatti C. & Lamura G., '*Home Care across Europe- Case studies. Italy*. EurHOMap. The European Observatory on Health Systems and Policies. A partnership hosted by the WHO. 2012

3.2.6 Home care system in the Netherlands

The Netherlands: structure	
The Netherlands is a unitary parliamentary representative democracy under a constitutional monarchy. It consists of 12 provinces and three islands in the Caribbean. It is a small but extremely densely populated country. The area's included for the IBenC study are Utrecht (city and region), region of West-Friesland, and the north of the North Holland province (respectively 14.9%, 25.5%, and 31% of the population over 65 years of age in the regions).	
Vision of home care	
Policy documents have considered home care in the context of an aging population, of autonomy and of the independent living clients. Themes are: a more integrated provision of home and institutional long-term care services, tailored to the clients' need. In 2006 government and stakeholders have developed a quality framework and norms for effective, efficient, safe and client-centred home care. In 2008 a governmental statement stressed the need for transparency to the public regard to the quality of care services and affordability and cost control in home care. Also legislative proposal was submitted at the end of 2013 to determine quality requirements for care providers by law. The Dutch health care policy aims to let people live in their own home for as long as possible, to maintain the affordability of care costs in the Netherlands: as a result of this, already more people received an indication for care at home than previous years. This so called extramuralisation of the low level care packages went into effect for January 1, 2013.[13] In addition, a new law becomes effective stating that as of 1 January 2015 persons up till the medium (third) care level need to be cared for in the community. This (also) affects about 15.000 persons currently already in residential settings.[14]	
Regulation on home care	
Nursing care and Personal care	Nursing and personal care in the Netherlands fall under the AWBZ (Exceptional Medical Expenses Act). The prime responsibility for home nursing and personal care is with the Ministry of Health, Welfare and Sport. This ministry develops legislation and regulation and supervises access, quality and efficiency. Nursing and personal care will shift to the regular health insurance act as of 2015.
Domestic care	Domestic care in the Netherlands falls under the WMO (Social Support Act). The essential actor for domestic care and supportive aids are the municipalities which develop local regulation on eligible services, organise assessment, finance providers and decide on prices and providers.

[13] Website Rijksoverheid: http://www.rijksoverheid.nl/onderwerpen/algemene-wet-bijzondere-ziektekosten-awbz/nieuws/2012/09/28/clienten-met-lichte-zorgvraag-wonen-langer-thuis.html

[14] http://www.rijksoverheid.nl/onderwerpen/algemene-wet-bijzondere-ziektekosten-awbz/vraag-en-antwoord/wat-gaat-er-veranderen-voor-mensen-die-gebruikmaken-van-zorg-uit-de-awbz-of-de-wmo.html

Eligibility for home care services	
Nursing care and Personal care	The Centre for Care Indication (CIZ) investigates whether a person is legally abided to the AWBZ (and thus assesses the needs for home care based on uniform criteria for most home nursing and personal care). The criteria are related to (1) the general health status, (2) the limitations in functioning as a consequence of the disease/handicap (3) the home and living environment (4) the psychological and physical functioning (5) the social circumstances (6) the amount and duration of currently offered care and (7) the best suitable client profile. Eligibility is independent of income. Anyone can take the initiative to apply for needs assessment. In case of home care, financed by the compulsory health insurance, the GP or medical specialists will assess the needs.
Domestic care	Municipalities set their own criteria for access to domestic aid and supportive aids. Eligibility is independent of income, availability of the service, but the personal situation is taken into account in the decision to allocate domestic care.
Freedom of choice of care provider	
Nursing and personal care	Clients being eligible to nursing or personal care can freely choose among available providers in their region. The desired provider may not always be the actual provider due to waiting lists. Care can be received in kind or via a Personal Budget (client buys his own care). In the latter case it is easier to select care providers.
Domestic care	Those being eligible for domestic aid may have a more limited choice due to the fact that many municipalities have contracted a limited number of agencies for these services. Care can be received in kind or via a Personal Budget (client buys his own care). In the latter case it is easier to select care providers.
Provision of home care	
Type of organisation	Most home care organisations are not-for profit, but the share of the commercial agencies is growing. There is also a revival of neighbourhood-centred home care services (Buurtzorg; small-scale autonomous professional teams).
Care professionals	• The professionals providing nursing care are certified nursing assistants and nurses (minimum 3 years vocational training). • The professionals providing personal care are home helps and certified nursing assistants (2 or 3 years vocational training). • The professionals providing domestic care are domestic workers, auxiliary helps, home helps and certified nursing assistants (no training up to 3 years vocational training)
Coordination and integration	Domestic care is separated from nursing and personal care. A recent development is the re-introduction of community nurses who will coordinate the care, living and wellbeing within one neighbourhood. This also includes the coordination between home care and GP's.

Funding of home care	
Health services funded by	Health services are funded by a mix of obligatory social and private insurance, with additional co-payments for long-term care.
Nursing and personal care	Long term care, including nursing and personal care at home, are being funded by the Health Insurance Act, the AWBZ (Exceptional Medical Expenses Act), statutory co-payments, private insurances and own payments.
Domestic care	Domestic care is funded by municipalities from resources received from a central fund and from income dependent co-payments.
Co-payment	
Nursing care and personal care	Co-payment for nursing and personal care services depends on the number of people in a house hold, age, accumulated income (care receiver and partner), the amount and types of services, the municipality one lives in.. The amount of the co-payment is determined by the CAK (Central Administration Office), a governmental body that collects the co-payments for care providers.
Domestic care	Co-payments are dependent on the number of people in a house hold, age, accumulated income (care receiver and partner), the amount and types of services, the municipality one lives in. The municipalities decide whether a co-payment is required for a service. In that case the amount of the co-payment is determined by the CAK (Central Administration Office), a governmental body that collects the co-payments for care providers.
Reimbursement	
Nursing care and personal care	For any type of care clients can opt for a Personal Budget by which any provider can be contracted. Clients receiving a personal budget for nursing or personal care must give account of their expenses once or twice a year and pay the obligatory co-payment. Mediating agencies have been established to support personal budget holders in their relationships with contracting providers.
Domestic care	Mediating agencies have been established to support personal budget holders in their relationships with contracting providers. Accountability rules for personal budget recipients for domestic care are set by the municipalities and may differ.
Informal care	Informal caregivers can be paid from a Personal Budget if they provide the care a care professional would provide otherwise. To prevent cases of overburdening, caregivers are eligible for respite care. In the Netherlands informal caregiver compliment (mantelzorgcompliment), reimbursement of € 200,- per year for primary informal caregiver, paid by the government. Care receivers need to nominate their informal caregivers to receive this.

Quality of home care	
Nursing and caring sector	The Health Care Inspectorate is responsible for the supervision on the quality of services. Inspection reports are made public. By law, home care agencies are obliged to systematically monitor and improve the quality of their services and staff and to annually report on it. This information is publicly available via a website. Home care agencies are obligatory to carry out client evaluations by independent third parties, according to standardised methods, every two year. The results are being made publicly available via a website. In 2012 start of the 'Kwaliteitsinstituut' (Quality Institute), a governmental body that aims to set a framework for measurement, monitoring and improvement of the quality of Dutch health care, taking into account the perspectives of the client, care provider, and health care insurer. Arrangements need to be laid down in a quality standard. This new institute puts pressure on the current health care system, in a sense that nobody knows how the quality of care will be assessed in the future. Health care insurers are more and more focusing on the assessments of quality of care and put this as an obligation in care contracts with care providers. The better the assessments are, the more money providers receive.
Domestic care	Municipalities were obligated to annually assess their clients' satisfaction with domestic aid services until 2012, since domestic care was supervised by municipalities from then and no quality standards were set by the Dutch municipalities. Some providers are still doing the assessments.

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3.3 Analyses of equity (ANCIEN project)

During the ANCIEN project (17), data on equity were collected in four countries, Germany, the Netherlands, Poland and Spain. Those countries each were considered to be representative for other countries (31). Applied to IBenC, it means that Germany also is representative for Belgium, Spain for Finland and Poland for Italy. Iceland was not included in the ANCIEN project. In this section, only the IBenC countries are named, but it is important to notice that only concerning Germany and the Netherlands, the data were effectively collected in the country.

The ANCIEN project focused on two key concepts of equity:

(1) Horizontal equity, which requires the equal treatment of individuals who are alike.
(2) Vertical equity, which requires the different treatment of individuals who are different.

Two types of equity were analysed: equity of revenue-raising and equity of resource allocation.

3.3.1 Equity of revenue-raising

Revenue-raising takes into account how resources are raised to fund care. The two key aspects of the revenue-raising system 'degree of risk pooling and coverage' and 'progressive' impact the potential for the care system to be more or less equitable.

The degree of risk pooling (or level of coverage of the dependency risk) is a key determinant of the performance of the system in terms of horizontal equity. Horizontal equity would require that individuals with the same resources pay the same amount of money into a long-term care scheme. The lower the degree of risk pooling, the more likely it is that people with higher levels of need (and possibly lower levels of resources) have to contribute higher resources to their care. Countries with a low degree of risk pooling tend to rely greatly on informal care.

Vertical equity deals with the extent to which the funds are raised in a way that is progressive (well-off people pay proportionally more), proportional (everyone pays an equal proportion of their resources), or regressive (well-off people pay proportionally less). The more progressive the system, the better its performance is in terms of vertical equity. Where the resources are raised in the form of informal care or with forms of payment that are regressive, the system will perform worse in terms of vertically equity.

The decision to score equity of revenue-raising is based on the level of informal care, private income, private insurance, social insurance and taxation. More information on the concept can be found in the ANCIEN report (17).

Table 8 summarises the results. The Netherlands perform score best in terms of equity of revenue-raising. This means that individuals with the same resources pay the same amount of money. Italy scores the lowest. People with higher levels of need have to contribute higher resources to their care. In Italy, people rely greatly on informal care. Also in terms of 'progressivity', The Netherlands score the highest and Italy the lowest. This also indicates that the resources are raised as informal care in Italy. In the Netherlands the funding of home care is largely from premiums, well-off people will pay proportionally more. Informal care is more limited compared to the other countries.

Table 8: Equity of revenue-raising. H = Horizontal equity; v = Vertical equity (ANCIEN project, 2012)

	Germany and Belgium*	The Netherlands	Italy*	Finland*	Iceland**
Degree of risk pooling and coverage (H)	Medium high	Very high	Low	Medium low	
Progressively (V)	Medium	High	Low	Medium low	

*Data collected in Germany is representative for Belgium, Poland represents Italy and Spain represents Finland.

** Iceland was not included in the ANCIEN project.

3.3.2 Equity of resource allocation

Equity of resource allocation is subdivided into 'equity of access and 'equity in levels and mix of services relative to needs'.

'Equity of access' is measured by looking at the extent in which people with the same level of needs (and resources) are able to access the system in the same way (= horizontal equity). Vertical equity implies that people with higher levels of need (or lower levels of resources) are able to access the system more easily.

For 'equity in levels and mix of services relative to needs', horizontal equity requires that people with the same levels of need would obtain the same package of care or size of benefits. Vertical equity would require that those with the highest levels of need receive a proportionally higher value of benefits. More information on both concepts can be found in the ANCIEN report (17).

Table 9 summarises the data. The Netherlands perform high in terms of equity, both horizontally and vertically. This indicates that the access to care is based on an individual assessment of care needs. Nevertheless, waiting lists are a problem in the Netherlands. Germany and Belgium score high in terms of horizontal equity, but low in terms of vertical equity. In these countries, people with the same level of needs (and resources) are able to access the system in the same way and they would obtain the same package of care or size of benefits. People with higher levels of need (or lower levels of resources) will not access the system more easily and they do not receive a proportionally higher value of benefits.

Table 9: Equity of resources allocation. H = Horizontal equity; v = Vertical equity (ANCIEN project, 2012)

	Germany and Belgium*		The Netherlands		Italy*		Finland*		Iceland**	
	H	***V***	***H***	***V***	***H***	***V***	***H***	***V***	***H***	***V***
Equity of access: means vs needs testing	High	Medium	High	High	Low	Low	Medium	Low		
Equity in levels and mix of services relative to needs	High	Low	High	High	Medium Low	Low	Low	Low		

*Data collected in Germany is representative for Belgium, Poland represents Italy and Spain represents Finland.

** Iceland was not included in the ANCIEN project.

3.4 Typology of long term care systems based on use and financing of care

According to the ANCIEN project (17), four types of long- term care systems can be distinguished, based on the use and financing of long-term care (both including residential and home-based care). The typology is based on four important characteristics:

(1) Public expenditures on long-term care (related to the GDP and the need for care)
(2) The share of private expenditures on long-term care
(3) The use of informal care (number of users related to the number of persons aged 65 and older)
(4) The support for informal caregivers

The typology of long-term care systems for the participating IBenC countries, according to the ANCIEN project is summarised in Table 10.

Table 10: Typology of long term care systems based on use and financing of care (ANCIEN, 2012)

	Belgium	The Netherlands	Germany	Italy	Finland	Iceland
Informal care oriented, low private financing	X		X			
Informal care oriented, high private financing					X	
Generous accessible and formalised		x				
High private financing, informal care seems necessity				x		

The long-term care systems in Belgium and Germany are characterised by a modest share of private spending, high informal care use and high informal care support. This is combined with a low level of public long-term care spending in Germany and a medium level of public long-term care spending in Belgium.

In Finland, the long-term care system shows many similarities with the Belgian and the German systems with regard to informal care use and support, but has a much higher level of private responsibilities and a somewhat higher level of public spending.

The long-term care system in the Netherlands is characterised by high public long-term care spending, low private spending, low informal care use and high informal care support.

The long-term care system in Italy is characterised by a small public sector involvement, more private spending, high informal care provision but few supportive measures for informal caregivers.

Iceland was not included in the ANCIEN analyses, so the data are not available. Based on the description of the macro level, based mostly on the EUHROMAP publications, Iceland can be placed in a cluster with the Netherlands, typified by generous accessible and formalised care. It is characterised by high public spending, low private spending and low informal care use. However, the Icelandic system differs from the Dutch one regarding informal care support, which is low in Iceland and high in the Netherlands.

4 Discussion on differences and similarities between the home care systems across the IBenC countries

4.1 Structure of the countries

Belgium and the Netherlands are both constitutional monarchies. Italy, Germany, Finland and Iceland are all republics. The IBenC countries are all wealthy countries, with the Netherlands being the wealthiest country and Italy (in comparison) the least wealthy.

Iceland and Finland have an extremely low population density and the Netherlands is extremely densely populated. The proportion of older people is the highest in Germany and Italy and the lowest in Iceland.

The areas defined for the IBenC project do not cover the whole country. Standardised information about the included areas in every country will be collected in the second year of the IBenC project, to identify any discrepancies between these areas and the country on a macro level, and to provide more insight into health care systems in Europe: while for some countries health care benefits and legislation are arranged on a national level, for others, like Germany, this varies per region.

4.2 Vision on home care

Most of the visions on home care underline the fact that it is important to stay at home for as long as possible. Integrated care, for example described as continuity of care or as a good coordination between care providers, is also an important topic. Germany, Belgium, the Netherlands and Finland underline the need of quality care. The need to invest in affordable care is mentioned in the vision of Belgium and the Netherlands. The importance of family caregivers is also cited in most visions. Remarkable is that the Italian law stated the importance of preventing social isolation of elderly people.

4.3 Regulation on home care

In all participating counties, the regulation of nursing care and domestic care is decentralised. Finland seems to have the most decentralised regulation, since municipalities are primarily responsible for home care (Finland exists out of 320 municipalities). Also in Belgium and in the Netherlands, the regulation of home care is strong decentralised. In Belgium, nursing care is a federal responsibility, while domestic care is mainly a community responsibility (Belgium is divided into three communities). In the Netherlands, the Ministry of Health, Welfare and Sport has the prime responsibility for home nursing, while the essential actors for domestic care are the municipalities. Nursing care in Germany belongs to the health sector, while home care, including personal and domestic care, belongs to the long-term care. The long-term care represents a separated pillar of the care system. Italy and Iceland seem to have the least decentralised home care regulation. The responsibilities of home nursing and domestic care are spread over two governmental departments. However, home nursing and social care services in Iceland are increasingly managed by the municipalities.

In the different countries, the definitions of nursing care and home care or family care are not the same. On the one hand, in Italy, the Netherlands and Iceland, the purpose of nursing care is to provide technical nursing activities by nurses. In Belgium, on the other hand, nursing care also includes personal care such as washing, toileting and dressing. In Germany, qualified nurses also

provide some ADL care and IADL care, but this type of care is clustered as home help care. Home help care consists of ADL care, IADL care, some basis nursing care and light supervision of simple medication. Personal care is mainly provided by primary caregivers or home care assistants in Finland. Nevertheless, because municipalities can independently decide upon job description, in some municipalities where nursing care is required, simple personal care is provided by a nurse too.

4.4 Eligibility for home care services

4.4.1 Nursing care

In all countries, a prescription by the general practitioner or by another physician is required in order to be eligible for technical nursing care. To be able to receive personal care by nurses, a certain level of ADL dependency is required in Belgium. This ADL dependency is measured by nurses by means of a structured instrument, the Index of ADL. In Germany, the members of the long-term care insurance are eligible for home care (which includes also some basic nursing care) if they are unable to fulfil basic ADL (or some IADL) functions for at least six months. Both Belgium and Germany score high in term of horizontal equity but low in terms of vertical equity (17). This means that people with the same level of need are able to access the home care system in the same way and they also would obtain the same care. However, people with higher level of needs will not access the home care system easier and they will not receive a proportionally higher value of benefits. In the Netherlands, the Centre for Care Indication (CIZ) assesses the need for home nursing and personal care based on uniform criteria. The criteria are related to 1) the general health status, 2) the limitations in functioning as a consequence of the disease/handicap, 3) the home and living environment, 4) the psychological and physical functioning, 5) the social circumstances, 6) the amount and duration of currently offered care, and 7) the best suitable client profile. The Netherlands scores high in terms of equity, which indicates that the access to care is obtained following an individual assessment of care needs. In Iceland, the needs assessments for home nursing are filled out by nurses who work for health centres or by nurses who are employed by the municipalities. The needs assessments are measured in a subjective way, without the use of a formal instrument. In Italy, nursing care is not only needs-tested but also the availability of informal caregivers is taken into account based on uniform criteria. There is a low equity of access in Italy. People with the same level of needs are not able to access the home care system in the same way.

4.4.2 Personal and domestic care

Eligibility criteria for personal and domestic care provided by non-nursing professionals are mainly established by the municipalities or by the providers, either based on national recommendations or not. In Flanders (Belgium), a form is used to measure the capacity of a person, but it is up to the providers to set the exact priority groups in accordance with the law.

Mostly, personal and domestic care is given to persons whose capacity is insufficient to manage their routine daily activities. Most of the eligibility is independent of income, except in Italy where home help is means-tested (next to needs-tested). In the Netherlands and in Belgium, the personal situation, such as the availability of informal care, is taken into account in the decision to allocate personal or domestic care. In Finland eligibility does not depend on the availability of informal caregivers. In Germany, it is required that a person is a member of the long-term care insurance and is unable to fulfil basic ADL (or some IADL) functions for at least six months. Only in Italy, a GP's certificate assessment is needed for personal and domestic care.

4.5 Freedom of choice of care provider

Theoretically, people are free to choose their own home care provider. In practice, however, this choice is hampered in several ways. Firstly, the services vouchers used in Italy and Finland are not available everywhere. For instance, in Italy, they are only available from accredited suppliers. A second hampering factor is the availability of the service provider in a community. In Iceland, there is some choice of provider in the larger communities, but it is more limited elsewhere because of the small size of the market. In Finland, private providers are not always available in the municipalities. Moreover, the private providers in Finland are free to decline a care request from the client. In the Netherlands, many municipalities have contracted a limited number of agencies for domestic care, thereby limiting the freedom of choice. A third factor is the waiting list in the Netherlands. In this way, the desired provider may not always be the actual provider. Finally, the choice is mainly made by others, e.g. by physicians and nurses in Italy or via affiliations of agencies to mutualities in Belgium.

4.6 Provision of home care

4.6.1 Organisations

With the exception of Germany, most of the home care organisations in the participating countries are not for profit organisations. In Germany, about 58% are private organisations that are working for profit. These organisations are very small, with a median of 18 clients served per organisation. However, the share of private or for profit organisations is also growing in the other countries. In Flanders (Belgium), it is estimated that half of the nursing care is already provided by self-employed or independent nurses. In Finland, private services and partnerships between public, private and third sector are the accepted solution for the increasing demand of care. In the Netherlands, the share of the commercial agencies is also growing, but there is also a growing revival of neighbourhood-centred home care services with small-scale autonomous professional team. Only in Iceland and Italy, there are only a few private organisations. Moreover, the private care organisations are an informal market and often fall outside the public regulations in Italy.

4.6.2 Care professionals

Belgium, Germany, Italy and The Netherlands scored ‘good’ on the question “Can your country’s patients see their primary-care doctor that same day (with or without an appointment)?” (19). Finland and Iceland scored ‘not-so-good’. The EHCI 2013 report concluded that the responses on this indicator show that there is no explanation for waiting times in primary care, there is no correlation with financial matters (GDP or healthcare spend per capita) nor with the range of services provided or with the density of the primary care network (including the number of GP’s per 1000 inhabitants).

Compared to other European countries, Belgium and the Netherlands score just below the average of 3.2 physicians per 1000 inhabitants (respectively 2.9 and 3.0). The other IBenC countries score above the European average with Italy having the highest score of 4.1 physicians per 1000 inhabitants. Belgium however does have the most GP’s and the most nurses per 1000 inhabitants (respectively 1.11 and 15.4). Iceland counts the lowest number of GP’s, but does have a high number of nurses (0.58 and 14.8 per 1000 inhabitants). Italy is the only IBenC country that scores below the European average of 8.7 nurses per 1000 inhabitants (6.3). The job description of nurses in home care differs. In Belgium and Germany, nurses also provide assistance in personal care such as washing and dressing of the clients. In Finland it is sometimes possible that nurses also provide personal care next

to nursing care. Municipalities can decide if nursing care is required, simple personal care can be provided by nurses too.

The large variation in the number of professionally active caring personnel per 1000 inhabitants is remarkable. Finland has 25.2 and the Netherlands 18.42 caring personnel per 1000 inhabitants. This is about three times higher than in Italy and Belgium (7.74 and 6.91). A possible explanation is to be found in the definition of active caring personnel (see footnote 12). Professionally active caring personnel include caring personnel active in care and for whom a certain level of education is a prerequisite for the job. Presumably, the education for e.g. home care aides is less formal in Belgium and Italy compared to the Netherlands and Finland. Professionals for domestic care, e.g. home care aides, do not need to meet an educational requirement in Belgium, while professionals for domestic care in Finland need a training of 1 year. In the Netherlands, the training for professionals for domestic care has a spread of no training up to a 3- year vocational training.

4.7 Funding of home care

The government expenditures (as % of the GDP) on health are approximately on the same level in all the IBenC countries. There is a range between 7% in Germany and 8.5 % in the Netherlands. In Germany, the government expenditures on health are just below the European average (7% versus 7.3%). In all other IBenC countries, the percentage is above average. This corresponds in part to the European Health Care Index 2013 indicator 'equity of healthcare systems', which is measured with the percentage of public healthcare spending (19). According to this indicator, in the Netherlands and in Iceland, the equity of healthcare systems is 'good', in the other IBenC countries the equity is 'so-so'.

Only a small part of the GDP is spent on long-term care at home. Finland and Belgium spent a little more than the European average (0,53 % of GDP), the Netherlands are at the average level and Italy and Germany are below this European average. In Iceland, Finland and Italy the main sources of health services funding are through national or municipal taxation. The Netherlands and Germany finance their health services primarily through obligatory insurances. In Belgium, there is a difference between the financing of nursing-personal care and family care (personal and domestic care). Care provided by nurses is mainly funded by public insurances, while family care is mainly funded by community taxation. Italy and Finland are countries with high private financing, Belgium and Germany by a modest share of private spending and the Netherlands by low private spending.

In all countries, a source of funding is the clients' co-payment, which is mostly means-tested. Sometimes no co-payment is needed for home nursing in Italy and Belgium. In Italy, this is the case for elderly meeting the eligibility criteria (needs-tested and availability of informal caregivers); in Belgium for widowers/widows, people with disabilities and pensioners. The EHCI report (19) mentioned that Belgium probably has the most generous healthcare system in Europe. In Germany, co-payments are required as the long-term care insurances benefits are generally insufficient to cover all costs for long-term care at home. In Finland, home care clients are in unequal position because the magnitude of co-payment depends on local authorities. Therefore, the co-payments depend on where they live.

4.8 Informal care

In the ANCIEN project (17), the long-term (home) care system in Finland, Belgium and Germany is characterised with high informal care use and high informal care support. In the Netherland, there is low informal care use, but high informal care support. The informal care support in these countries consists of cash benefits and respite care. In Belgium and Germany, informal caregivers can also take a career break, but only in Belgium a monthly career break financial compensation is available. In Belgium and Germany, there is also the possibility to follow courses, e.g. in care giving or on home care and dementia.

Iceland is known as a country with low informal care use and low informal care support. Financial compensation may be available if a spouse has suffered a loss of income as a result of stopping full-time employment to provide care at home.

Finally, Italy is seen as a country where informal care is a necessity. In the ANCIEN project Italy is categorised as a country with few supportive measures for informal caregivers but this is somewhat inconsistent with the data of the description of the home care system per country. In Italy, informal caregivers can be paid by the clients through care allowances. Additionally, there are measures for working caregivers in terms of flexible working times and paid or unpaid care leaves and also deduction from income tax is possible. Informal caregivers are considered to be co-clients with needs to be taken into account and measures for supporting informal caregivers also contain day-centres for the clients, self-help groups and respite care.

4.9 Quality of home care

In all countries, some rules and regulations about quality of care exist. However, there is variety in the way the quality of care regulations are operationalised. In Belgium, quality control of the care provided by nurses is almost absent. In Flanders (a part of Belgium), a Flemish Quality degree stated that every two years nursing care providers must self-evaluate the process, structure and outcome of care, including an assessment of the clients' satisfaction. However, this is not applicable for the independent nurses, who represent about 50% of the nurses who provide care at home. In Italy, the evaluation of the results and the recording of operational data are also limited. In Finland, the municipalities are responsible for organising high quality care by using a framework for quality of care for the elderly, developed by the Association of Finnish Local and regional Authorities and the Ministry of Social affairs and Health. This framework contains values, ethical principles and strategies to increase the quality and the effectiveness, but it does not include quality criteria. One fourth of the municipalities in Finland used interRAI systems to monitor their quality of home-care in 2012. In Iceland, the interRAI-Home care instrument was also recently introduced for clients who are 80 years an older. Seven of the 20 interRAI-Home care quality indicators will be published in the annual report. In Germany and the Netherlands, the quality of care is examined by an external organisation (The Medical Services of the Health Insurance Institution in Germany and Health Care Inspectorate in the Netherlands). In the Netherlands, the inspection reports are also made public. The obligatory annual reports of the home care organisations are also publicly available via a website. Even more, health care insurers are more and more focusing on the assessment of quality of care and put this as an obligation in care contract with care providers. The better the assessments, the more money providers will receive.

5 Conclusion

From a patient perspective, the Netherlands have the best healthcare system in Europe. This conclusion is based on 48 indicators, categorised into six subscales: patient rights and information, accessibility/waiting time for treatment, outcomes, range and reach of services ('generosity'), prevention and pharmaceuticals. However, of the 34 participating countries, 5 out of 6 IBenC countries score in the top 10. Only Italy scores lower, with a place ranking of 20. The EHCI 2013 report argued that Italy provides healthcare services in which medical excellence can be found in many places. However, real excellence seems to be very dependent on the clients' ability to afford private healthcare as a supplement to public healthcare. The same conclusion can be made according to the home care system description of Italy and based on the ANCIEN report. Italy is wealthy, but somewhat less wealthy compared to the other IBenC countries. It has a small public care sector involvement and private spending is needed. This also implies that there is a low equity of access to long term care in Italy. People with the same level of need are not able to access the home care system in the same way. Therefore, Italy essentially has to rely on informal care. This is in contrast with the Netherlands. Compared to the other IBenC countries and to Europe, the Netherlands are wealthier and there is little informal care use. The Netherlands have the most formal home care, with a high quality of care regulations. The quality of care is examined by an external organisation and the inspection reports and obligatory annual reports of the home care organisations are publicly available. However, this also means that home care in the Netherlands is more expensive. The Netherlands also score high in terms of equity of access. The access to care is obtained based on an individual assessment of care needs.

From a patient perspective, Belgium has the most generous healthcare system in Europe. Together with Germany, Belgium is characterised by a modest share of private spending, high informal care use and high informal care support. This is combined with a low level of public long-term care spending in Germany and a medium level of public long-term care spending in Belgium. Remarkable in Belgium, is the definition of nursing care. While in Italy, the Netherlands and Iceland the purpose of nursing care is to provide technical nursing activities by nurses, nursing care in Belgium also includes personal care such as washing, toileting and dressing. Belgium also has the most nurses per 1000 inhabitants. In Germany, nurses also provide assistance in the (instrumental) activities of daily living, but this type of care is not clustered in nursing care, but in home help care. Remarkable for Germany, are the many private home care organisations which are very small (a median of 18 clients served per organisation). Because municipalities can independently decide upon job description in Finland, in some municipalities where nursing care is required, simple personal care is provided by a nurse too.

The municipalities' decision making in Finland is not only reflected in the job description of care professionals, but also in the whole home care system regulation. Since the 320 Finnish municipalities are primarily responsible for home care, it is safe to say that Finland has the most decentralised home care regulation of all IBenC countries. Italy and Iceland have the least decentralised home care regulation. Two governmental departments are responsible for home nursing and domestic care. However, home nursing and social care services in Iceland are also increasingly managed by the municipalities. The home care system in Iceland is less formal. This may partly be due to the fact that Iceland has the youngest population, along with the fact that the

population density is very low. However, the population is also aging in Iceland. Therefore, they are also preparing for future home care.

In summary, the Netherlands have the most formal home care with low informal care use, while Italy essentially has to rely on informal care. Home care in Belgium distinguishes itself from the others by the definition of nursing care, which also includes personal care such as washing, toileting and dressing. In Germany, more than half of the home care organisations are for profit and are very small. Since municipalities are primarily responsible for home care in Finland, Finland has the most decentralised home care regulation. Finally, the home care system in Iceland is less formal, due to the young population. Nevertheless, Iceland is also preparing the home care system for an ageing population.

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